Applicant or Provider Legal Name: Date:

Medi-Cal Provider Number: ______________________________ Page _____ of _____ pages
(Not required for new applicants to the Medi-Cal program.)

MEDI-CAL DISCLOSURE STATEMENT

PRINT OR TYPE IN BLACK INK

1. List the requested information below for each person with an ownership or control interest in applicant or provider, including corporate officers and directors for corporations and all partners in partnerships. If additional sheets are needed, use copies of this page and attach to the application package. **Each person listed below shall complete Attachment A.**

Full Legal Name:
(Last) (First) (Middle)

Residence Address:
(Street) (City) (State) (9-digit zip code)

Driver's License Number or State-Issued Identification Number:
(attach copy):

Is this person related to any other person with an ownership or control interest in applicant or provider? Yes ☐ No ☐
If yes, please describe:
☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ Other Explain: ____________________

Full Legal Name:
(Last) (First) (Middle)

Residence Address:
(Street) (City) (State) (9-digit zip code)

Driver's License Number or State-Issued Identification Number:
(attach copy):

Is this person related to any other person with an ownership or control interest in applicant or provider? Yes ☐ No ☐
If yes, please describe:
☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ Other Explain: ____________________

Full Legal Name:
(Last) (First) (Middle)

Residence Address:
(Street) (City) (State) (9-digit zip code)

Driver's License Number or State-Issued Identification Number:
(attach copy):

Is this person related to any other person with an ownership or control interest in applicant or provider? Yes ☐ No ☐
If yes, please describe:
☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ Other Explain: ____________________

Full Legal Name:
(Last) (First) (Middle)

Residence Address:
(Street) (City) (State) (9-digit zip code)

Driver's License Number or State-Issued Identification Number:
(attach copy):

Is this person related to any other person with an ownership or control interest in applicant or provider? Yes ☐ No ☐
If yes, please describe:
☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ Other Explain: ____________________

Full Legal Name:
(Last) (First) (Middle)

Residence Address:
(Street) (City) (State) (9-digit zip code)

Driver's License Number or State-Issued Identification Number:
(attach copy):

Is this person related to any other person with an ownership or control interest in applicant or provider? Yes ☐ No ☐
If yes, please describe:
☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ Other Explain: ____________________

Applicant or Provider Legal Name:	Date:

Medi-Cal Provider Number: ______________________________ Page ____ of ____ pages
(Not required for new applicants to the Medi-Cal program.)

MEDI-CAL DISCLOSURE STATEMENT (Continued)

2. List the requested information for each person, including corporate officers and directors for corporations and all partners in partnerships, with an ownership or control interest in any subcontractor in which applicant or provider has a direct or indirect ownership interest of five (5) percent or more. If additional sheets are needed, make copies of this page and attach to the application package.

Full Legal Name:
____
(Last) (First) (Middle)

Residence Address:
____
(Street) (City) (State) (9-digit zip code)

Subcontractor Full Name:
____

Subcontractor Address:
____
(Street) (City) (State) (9-digit zip code)

Is this person related to any other person with an ownership or control interest in applicant or provider listed in Number 1? ☐ Yes ☐ No
If yes, please describe:
☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ Other Explain: ______________________________

Full Legal Name:
____
(Last) (First) (Middle)

Residence Address:
____
(Street) (City) (State) (9-digit zip code)

Subcontractor Full Name:
____

Subcontractor Address:
____
(Street) (City) (State) (9-digit zip code)

Is this person related to any other person with an ownership or control interest in applicant or provider listed in Number 1? ☐ Yes ☐ No
If yes, please describe:
☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ Other Explain: ______________________________

Full Legal Name:
____
(Last) (First) (Middle)

Residence Address:
____
(Street) (City) (State) (9-digit zip code)

Subcontractor Full Name:
____

Subcontractor Address:
____
(Street) (City) (State) (9-digit zip code)

Is this person related to any other person with an ownership or control interest in applicant or provider listed in Number 1? ☐ Yes ☐ No
If yes, please describe:
☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ Other Explain: ______________________________

Full Legal Name:
____
(Last) (First) (Middle)

Residence Address:
____
(Street) (City) (State) (9-digit zip code)

Subcontractor Full Name:
____

Subcontractor Address:
____
(Street) (City) (State) (9-digit zip code)

Is this person related to any other person with an ownership or control interest in applicant or provider listed in Number 1? ☐ Yes ☐ No
If yes, please describe:
☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ Other Explain: ______________________________

Applicant or Provider Legal Name:	Date:

Medi-Cal Provider Number: _____ Page ____ of ____ pages
(Not required for new applicants to the Medi-Cal program.)

MEDI-CAL DISCLOSURE STATEMENT (Continued)

3. List the requested information for each person, including corporate officers and directors for corporations and all partners in partnerships, with an ownership or control interest in any subcontractor with whom the applicant or provider has had business transactions totaling more than $25,000 during the 12-month period immediately preceding the date of the application, or immediately preceding the date on the Department Health Services' request for such information. If additional sheets are needed, please use copies of this page and attach to the application package.

Full Legal Name:
_____
(Last) (First) (Middle)

Residence Address:
_____
(Street) (City) (State) (9-digit zip code)

Explain:
_____
_____
_____

Full Legal Name:
_____
(Last) (First) (Middle)

Residence Address:
_____
(Street) (City) (State) (9-digit zip code)

Explain:
_____
_____
_____

Full Legal Name:
_____
(Last) (First) (Middle)

Residence Address:
_____
(Street) (City) (State) (9-digit zip code)

Explain:
_____
_____
_____

Full Legal Name:
_____
(Last) (First) (Middle)

Residence Address:
_____
(Street) (City) (State) (9-digit zip code)

Explain:
_____
_____
_____

Full Legal Name:
_____
(Last) (First) (Middle)

Residence Address:
_____
((Street) (City) (State) (9-digit zip code)

Explain:
_____
_____
_____

Applicant or Provider Legal Name:	Date:

Medi-Cal Provider Number: _____
(Not required for new applicants to the Medi-Cal program.)

MEDI-CAL DISCLOSURE STATEMENT (Continued)

4. List any significant business transactions between the applicant or provider, including corporate officers and directors for corporations and all partners in partnerships, and any wholly owned supplier, during the five-year period ending on the date of the application, or ending on the date of the written request by the Department for such information. If additional sheets are needed, use copies of this page and attach to the application package.

Name of Supplier:
Explain:

Name of Supplier:
Explain:

Name of Supplier:
Explain:

Name of Supplier:
Explain:

Name of Supplier:
Explain:

Name of Supplier:
Explain:

Name of Supplier:
Explain:

Applicant or Provider Legal Name:	Date:

Medi-Cal Provider Number: _____
(Not required for new applicants to the Medi-Cal program.)

MEDI-CAL DISCLOSURE STATEMENT (Continued)

5. List any significant business transactions between the applicant or provider, including corporate officers and directors for corporations and all partners in partnerships, and any subcontractor, during the five-year period ending on the date of the application, or ending on the date of the written request by the Department for such information. If additional sheets are needed, use copies of this page and attach to the application package.

Name of Subcontractor:
Explain:

Name of Subcontractor:
Explain:

Name of Subcontractor:
Explain:

Name of Subcontractor:
Explain:

Name of Subcontractor:
Explain:

Name of Subcontractor:
Explain:

Name of Subcontractor:
Explain:

Applicant or Provider Legal Name:	Date:

Medi-Cal Provider Number: _____
(Not required for new applicants to the Medi-Cal program.)

MEDI-CAL DISCLOSURE STATEMENT (Continued)

6.a. Has applicant, provider, any person with an ownership or control interest in applicant or provider, agent or managing employee ever been convicted of any felony or misdemeanor involving fraud or abuse in any government program? ☐ Yes ☐ No
If yes, please give the name, date of conviction and explain:

b. Has applicant, provider, any person with an ownership or control interest in applicant or provider, agent or managing employee ever been found liable for fraud or abuse in any civil proceeding? ☐ Yes ☐ No
If yes, please give the name, date of final judgement and explain:

c. Has applicant, provider, any person with an ownership or control interest in applicant or provider, agent or managing employee ever entered into a settlement in lieu of conviction for fraud or abuse? ☐ Yes ☐ No
If yes, please give the name, date of settlement and explain:

7. Has applicant or provider ever participated in the Medi-Cal program? ☐ Yes ☐ No
If yes, please provide the following information:

Name(s)	Medi-Cal Provider Number(s)

8. Has applicant or provider ever participated in another state's Medicaid program? ☐ Yes ☐ No
If yes, please provide the following information:

State	Full Legal or Business Name	Medicaid Provider Number(s)

9. Has applicant or provider ever been suspended from a Medicare or Medicaid program? ☐ Yes ☐ No
If yes, please provide the following information:

Effective Date(s) of Suspension(s)	Date(s) of Reinstatement(s), as applicable	Medicare and/or Medicaid Provider Number(s)

10. Has the individual license, certificate, or other approval to provide health care, of the applicant or provider, ever been suspended or revoked? ☐ Yes ☐ No
If yes, please attach a copy of the written confirmation from the licensing authority that his/her professional privileges have been restored and provide the following information:

State(s) in Which Action Was Taken	Effective Date(s) of Licensing Authority's Action

Applicant or Provider Legal Name:	Date:

Medi-Cal Provider Number: _____
(Not required for new applicants to the Medi-Cal program.)

MEDI-CAL DISCLOSURE STATEMENT (Continued)

11. Is applicant or provider a pharmacy? ☐ Yes ☐ No

If yes, has the individual license, certificate, or other approval to provide health care, of the pharmacist-in-charge, ever been suspended or revoked? ☐ Yes ☐ No

If yes, please attach a copy of the written confirmation from the licensing authority that his/her professional privileges have been restored and provide the following information:

State(s) in Which Action Was Taken	Effective Date(s) of Licensing Authority's Action

12. Has applicant or provider otherwise lost or surrendered that license, certificate, or other approval while a disciplinary hearing was pending? ☐ Yes ☐ No

If yes, please attach a copy of the written confirmation from the licensing authority that his/her professional privileges have been restored and provide the following information:

State(s) in Which Action Was Taken	Effective Date(s) of Licensing Authority's Action

13. Is applicant or provider a pharmacy? ☐ Yes ☐ No

If yes, has the individual license, certificate, or other approval to provide health care, of the pharmacist-in-charge, ever been lost or surrendered? ☐ Yes ☐ No

If yes, please attach a copy of the written confirmation from the licensing authority that his/her professional privileges have been restored and provide the following information:

State(s) in Which Action Was Taken	Effective Date(s) of Licensing Authority's Action

14. Has any licensing authority disciplined the applicant or provider? ☐ Yes ☐ No

If yes, provide the following information:

Action Taken	Where	Effective Date(s) of Licensing Authority's Action

15. Is applicant or provider a pharmacy? ☐ Yes ☐ No

If yes, has any licensing authority ever disciplined the pharmacist-in-charge? ☐ Yes ☐ No

If yes, provide the following information:

Action Taken	Where	Effective Date(s) of Licensing Authority's Action

16. Specify type of applicant or provider:

☐ Partnership* ☐ Unincorporated Sole Proprietorship ☐ Corporation** ☐ Limited Liability Corporation

* Attach a copy of the fully executed partnership agreement.
** Attach certified copies of the Articles of Incorporation, certified copy of the Statement of Officers and a copy of Certification of Good Standing issued by the Secretary of State.

Applicant or Provider Legal Name:	Date:

Medi-Cal Provider Number: _____
(Not required for new applicants to the Medi-Cal program.)

MEDI-CAL DISCLOSURE STATEMENT (Continued)

17. Does applicant or provider intend to sell or currently sell incontinence medical supplies? ☐ Yes ☐ No
If yes, list the names and addresses for all current sources of capital:

Full Name (including Last, First, Middle)	Address (including street, city, state and 9-digit zip code)

18. Does applicant or provider intend to sell or currently sell incontinence medical supplies? ☐ Yes ☐ No
If yes, list all manufacturers, suppliers and other providers with whom the applicant or provider has any type of business relationship relative to the goods or services provided to Medi-Cal beneficiaries.

Business Name	Business Address	Business Phone Number

19. Does applicant or provider intend to sell or currently sell incontinence medical supplies? ☐ Yes ☐ No
If yes, list all entities to which the applicant or provider has extended a line of credit.

Name	Address

Applicant or Provider Legal Name:	Date:

Medi-Cal Provider Number: _____
(Not required for new applicants to the Medi-Cal program.)

I declare under penalty of perjury under the laws of the state of California that the foregoing information in this document, in the attachments, the disclosure statement, and provider agreement are true, accurate, and complete to the best of my knowledge and belief. I declare that I have the authority to legally bind the applicant or provider.

20. Printed Name of Applicant or Provider: _____

21. Signature (blue ink only): _____

22. Executed at _____ (City), _____ (State), on _____ (Date).

23. Notary Public:*

* Those applicants and providers licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act are not required to have this document notarized.

Privacy Statement
(Civil Code Section 1798 et seq.)

All information requested by the application, the disclosure statement and the provider agreement is mandatory with the exception of the social security number for any person other than the person or entity for whom an IRS Form 1099 must be provided by the department pursuant to 26 USC 6041. This information is required by the Department of Health Services, Payment Systems Division, by the authority of Welfare and Institutions Code section 14043.2(a). The consequences of not supplying the mandatory information requested are denial of enrollment as a Medi-Cal provider and issuance of the Medi-Cal provider number or denial of continued enrollment as a provider and the deactivation of all Medi-Cal provider numbers used by the provider to obtain reimbursement from the Medi-Cal program. The consequence of not supplying the voluntary social security number information requested is delay in the application process while other documentation is used to verify the information supplied. Any information provided will be used to verify eligibility to participate as a provider in the Medi-Cal program. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, the Department of Corporations, or other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare fiscal intermediaries, Health Care Financing Administration, Office of the Inspector General, and Medicaid and licensing programs in other states. For more information or access to records containing your personal information maintained by this agency, contact the Chief, Payment Systems Division, 714 P Street, Room 950, Sacramento, CA 95814, (916) 323-1945.

ATTACHMENT A

Applicant or Provider Legal Name:	Date:

Medi-Cal Provider Number: _____ Page _____ of _____ pages
(Not required of applicants new to the Medi-Cal program.)

A COPY OF THIS ATTACHMENT SHALL BE COMPLETED AND SUBMITTED TO APPLICANT OR PROVIDER BY EACH PERSON LISTED ON PAGE ONE OF THIS MEDI-CAL DISCLOSURE STATEMENT. APPLICANT OR PROVIDER SHALL SUBMIT ALL PAGES OF ATTACHMENT A WITH THE APPLICATION PACKAGE.

Your name (Person listed for Number 1 on Disclosure Statement): _____

1. List the name and address of any other health care provider you also have an ownership or control interest in. If additional sheets are needed, use copies of this page and attach to the application package.

Full Name of Health Care Provider	Address (including street, city, and 9-digit zip code)

2.a. Have you ever been convicted of any felony or misdemeanor involving fraud or abuse in any government program? Yes ☐ No ☐
If yes, please explain:

b. Have you ever been found liable for fraud or abuse in any civil proceeding? Yes ☐ No ☐
If yes, please explain:

c. Have you ever entered into a settlement in lieu of conviction for fraud or abuse, within the previous five years? Yes ☐ No ☐
If yes, please explain:

Applicant or Provider Legal Name:	Date:

Medi-Cal Provider Number: _____
(Not required for applicants new to the Medi-Cal program.)

3. Have you ever participated in the Medi-Cal program? Yes ☐ No ☐
If yes, please provide the following information:

Name(s)	Medi-Cal Provider Numbers

4. Have you ever participated in another state's Medicaid program? Yes ☐ No ☐
If yes, please provide the following information:

State	Full Legal or Business Name	Medicaid Provider Number

5. Have you ever been suspended from a Medicare or Medicaid program? Yes ☐ No ☐
If yes, please provider the following information:

Effective Date(s) of Suspension(s)	Date(s) of Reinstatement(s), as applicable	Medicare and/or Medicaid Provider Number

6. Has your individual license, certificate, or other approval to provide health care, ever been suspended or revoked? Yes ☐ No ☐
If yes, please attach a copy of the written confirmation from the licensing authority that his/her professional privileges have been restored and provide the following information:

Action Taken	Where Action Was Taken	Effective Date(s) of Licensing Authority's Action

7. Have you otherwise lost or surrendered your license, certificate, or other approval while a disciplinary hearing was pending? Yes ☐ No ☐
If yes, please attach a copy of the written confirmation from the licensing authority that his/her professional privileges have been restored and provide the following information:

Action Taken	Where Action Was Taken	Effective Date(s) of Licensing Authority's Action

8. Have you ever been disciplined by any licensing authority? Yes ☐ No ☐
If yes, provide the following information:

Action Taken	Where Action Was Taken	Effective Date(s) of Licensing Authority's Action

COMPLETION INSTRUCTIONS FOR
THE MEDI-CAL DISCLOSURE STATEMENT

IMPORTANT: Remember to note in the upper right-hand corner of each page of this Medi-Cal Disclosure Statement, the page numbers and the total number of pages to be submitted with the application package.

1. List full legal name, including last, first and middle names, for each person or corporation with an ownership or control interest in applicant or provider (including officers and directors of an applicant or provider that is organized as a corporation and partners in an applicant or provider that is organized as a partnership) as listed with the Internal Revenue Service (IRS).
   - Person with an Ownership or Control Interest means a person or corporation that:
     - has an ownership interest of five (5) percent or more in an applicant or provider;
     - has an indirect ownership interest equal to five percent (5) or more in an applicant or provider;
     - has a combination of direct and indirect ownership indirect ownership interest equal to five (5) percent or more in an applicant or provider;
     - owns an interest of five (5) percent or more in any mortgage, deed of trust, note, or other obligation secured by the applicant or provider if that interest equals at least five percent of the value of the property or assets of the applicant or provider;
     - **is an officer or director of an applicant or provider that is organized as a corporation;**
     - **is a partner in an applicant or provider that is organized as a partnership**.
   - To determine percentage of ownership, mortgage, deed of trust, note or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation.
     - For example, if A owns ten (10) percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to six (6) percent and shall be reported.
     - Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to four (4) percent and need not be reported.
   - Indirect Ownership Interest means an ownership interest in any entity that has an ownership interest in the applicant or provider. This term includes an ownership interest in any entity that has an indirect ownership interest in the applicant or provider. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity.
     - For example, if A owns ten (10) percent of the stock in a corporation which owns 80 percent indirect ownership interest in the applicant or provider and shall be reported.
     - Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the applicant or provider, B's interest equates to a four (4) percent indirect ownership interest in the applicant or provider, B's interest equates to a four (4) percent indirect ownership interest in the applicant or provider and need not be reported.
   - Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity.
   - Residence means the address where the named person lives.
   - Driver's License Number or State Identification Number means the driver's license or identification number issued by the state of residence. Attach an enlarged, legible copy with the application.
   - Check the box that defines the relationship between person named in No. 1 and applicant or provider, if applicable.

2. List the requested information regarding anyone that has an ownership or control interest in a subcontractor that applicant or provider also has a direct or indirect ownership interest in.
   - Subcontractor means an individual, agency or organization: 1) to which applicant or provider has contracted or delegated some of its management functions or responsibilities of providing medical care services, equipment or supplies to its patients, and 2) with whom an applicant or provider has entered into a contract, agreement, purchase order, lease or leases for property, space, supplies, equipment, or services provided under the Medi-Cal agreement.
   - Ownership interest means the possession of equity in the capital, the stock, or the profits of the applicant or provider.
   - Capital means the total of all money invested in, and property or services contributed to, an applicant's or provider's business enterprise for the purpose of starting, acquiring, equipping, and operating the applicant's or provider's business enterprise.
   - Indirect ownership interest means an ownership interest in any entity that has an ownership interest in the applicant or provider, including an ownership interest in any entity that has an indirect ownership interest in the applicant or provider.

3. List the requested information for any person named in No. 1 that has an ownership or control interest in any subcontractor with whom the applicant or provider has had business transactions totaling more than $25,000 during the 12-month period immediately preceding the date of this application, or immediately preceding the date on the Department's request for such information.

4. List the requested information regarding significant business transactions between any wholly-owned supplier and applicant or provider during the five years prior to the date on the application or the period ending on the date of the Department's written request for such information.
   - Significant Business Transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 or five percent of a applicant's or provider's total operating expenses.
   - Wholly Owned Supplier means a supplier whose total ownership interest is held by an applicant or provider or by a person, persons, or other entity with an ownership or control interest in an applicant or provider.

COMPLETION INSTRUCTIONS (Continued)

5. List the requested information regarding significant business transactions between any subcontractor and applicant or provider during the five years prior to the date on the application or the period ending on the date of the Department's written request for such information. (See Nos. 2 and 4 above.)
6. Check the appropriate boxes and explain any " Yes" answers.
7. Check the appropriate box and list all previous Medi-Cal provider numbers, if appropriate.
8. Check the appropriate box and list the state(s), name(s) applicant or provider used when participating in another state Medicaid program, and all applicable provider numbers.
9. Check the appropriate box and, if applicable, provide the effective date(s) of suspension(s), date(s) of reinstatement and Medicare and/or Medicaid provider number.
10. Check the appropriate box and, if appropriate, list the requested information and attach a copy of the letter(s) of reinstatement.
11. Check the appropriate boxes and, if appropriate, list the requested information and attach a copy of the letter(s) of reinstatement for the pharmacist-in-charge.
12. Check the appropriate box and, if applicable, list the state(s) where applicant's or provider's license, certificate or other approval to provide health care was suspended or revoked and the effective dates of those actions. Attach the written confirmation that professional privileges have been restored.
13. Check the appropriate boxes and, if applicable, list the state(s) where the license, certificate or other approval to provide health care of the pharmacist-in-charge was suspended or revoked and the effective dates of those actions. Attach the written confirmation that professional privileges have been restored.
14. Check the appropriate box and, if applicable, list the state(s) where the applicant's or provider's license, certificate, or other approval to provide health care was lost or surrendered while a disciplinary hearing was pending and the effective dates of those actions. Attach the written confirmation that professional privileges have been restored.
15. Check the appropriate boxes and, if applicable, list where the license, certificate, or other approval to provide health care of the pharmacist-in-charge was lost or surrendered while a disciplinary hearing was pending and the effective dates of those actions. Attach the written confirmation that professional privileges have been restored.
16. Check the appropriate box to indicate the type of ownership related to applicant or provider business and attach a certified copy of the Articles of Incorporation, a certified copy of the Statement of Officers and a Statement of Good Standing from the Secretary of State.
17. If applicant or provider intends to sell or currently sells incontinence medical supplies, list the full legal name(s) and address(es) of all current sources of capital.
    - Capital means the total of all money invested in, and property or services contributed to, an applicant's or provider's business enterprise for the purpose of starting, acquiring, equipping, and operating the applicant's or provider's business enterprise.
18. If applicant or provider intends to sell or currently sells incontinence medical supplies, list all manufacturers, suppliers and other providers with which the applicant or provider has any type of business relationship.
    - Supplier means any manufacturer, principal labeler, wholesaler and any other primary supplier from which an applicant or provider purchases goods and services used in carrying out its responsibilities under Medi-Cal.
19. If applicant or provider intends to sell or currently sells incontinence medical supplies, list all entities to which the applicant or provider has extended a line of credit.
    - Line of Credit means a right granted by an applicant or provider to any other person or entity to defer payment to applicant or provider for the purchase of goods or services from applicant or provider up to a predetermined number of amount of goods or services or a predetermined amount of money.
20. Print the name of the individual signing the Medi-Cal Disclosure Statement.
21. An original signature (blue ink only) of the individual listed in No. 16 is required.
22. Include the city, state, and date in the statement regarding where and when the application was signed.
23. The MEDI-CAL DISCLOSURE STATEMENT is to be notarized by a Notary Public unless applicant or provider is licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act.

Attachment A Completion Instructions

1. Provide the name and address of all health care providers other than applicant or provider in which you also have an ownership or control interest. (See Number 1 above for definitions.)
2. Check the appropriate boxes and explain any " Yes" answers.
3. Check the appropriate box and list all previous Medi-Cal provider numbers, if appropriate.
4. Check the appropriate box and list the state(s), name(s) applicant or provider used when participating in another state Medicaid program, and all applicable provider numbers.
5. Check the appropriate box and, if appropriate, list the requested information and attach a copy of the letter(s) of reinstatement.
6. Check the appropriate box and, if applicable, list the state(s) where the applicant's or provider's license, certificate or other approval to provide health care was suspended or revoked and the effective dates of those actions. Attach the written confirmation that professional privileges have been restored.
7. Check the appropriate box and, if applicable, and list the state(s) where the applicant's or provider's license, certificate, or other approval to provide health care was lost or surrendered while a disciplinary hearing was pending and the effective dates of those actions. Attach the written confirmation that professional privileges have been restored.
8. Check the appropriate box and, if applicable, indicate where the action was taken and the effective date of the action.